Multiple Psychiatric Medications in the Treatment of Child and Adolescent Psychiatric Disorders

Recent surveys of psychotropic drug usage over the last decade report an increase in polypharmacy in youth with psychiatric disorders. There are many factors that can lead to the use of multiple medications in children and adolescents. While treatment decisions should always reflect the results of evidence-based best practice guidelines, clinicians treating youth with psychiatric disorders find disappointingly little guidance from the psychiatric literature. There are only a small number of either well-designed and useful studies completed on youth or comprehensive practice guidelines from the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry. Additionally, many of the older psychotropic drugs in common usage with children and adolescents have not had the stringent clinical trials that the FDA currently requires.

Practice Challenges

Significant practice challenges are posed by limited scientific evidence and few consensus guidelines for treating children and adolescents with psychiatric disorders. This situation is further complicated by the need to distinguish symptoms of psychiatric disorders from developmental changes, and to respond to the pleas of concerned teachers and parents. It is crucial to obtain input from parents as part of the evaluation. It may also be important to explain that there may not be a “quick fix” for psychiatric symptoms, and that developmental changes complicate determination of diagnosis. Often, practitioners undertake evaluation and treatment in a context of crisis and decreased hospital lengths of stay. Medication trials are one of a few reasons why insurance companies will approve additional hospital days. However, many practitioners attempt to treat psychiatric symptoms in youth by prescribing medications for which there is no clear evidence-based support or expert consensus recommendation. In these cases, achieving the ideal, meticulous, single-drug medication trial is even more difficult. Inappropriate medication usage, as well as the use of multiple medications may result.

Despite these challenges, the use of multiple medications may be appropriate in the treatment of some children and adolescents with complex psychiatric disorders. For example, if a child has several psychiatric diagnoses that are uniquely responsive to different classes of medications, a clinician may prescribe several medications (e.g., a child with Tourette’s syndrome, OCD and ADHD may require a psychostimulant, a SSRI antidepressant and, possibly another medication.

Jellinek cites, with caution, the benefit of combined pharmacotherapy in its effective reduction of psychiatric symptoms that allows for other interventions to take hold. For example, a child with severe OCD whose symptoms are only partially responsive to fluvoxamine and cognitive-behavioral therapy may benefit more fully from the addition of a small dose of clomipramine.

The addition of another drug, to treat the side effects of intervention, is appropriate and the preferred method of treatment. For example, a child with psychosis who is treated with risperidone and develops severe EPS may be prescribed an anti-cholinergic to

relieve the EPS symptoms. An example of treatment with an older drug not subjected to current prevailing FDA standards is the use of trazodone as a hypnotic.

The National Association of State Mental Health Program Directors' (NASMHPD) has identified the following risks inherently associated with polypharmacy:

- The use of multiple medications increases the risk for medication-related adverse events and drug interactions.
- The use of multiple medications creates a more complicated drug regimen for the patient, potentially making adherence more difficult.
- Multiple medications may confound the effects of one another.
- Where medications are used to treat the side effects of other medications, polypharmacy potentially creates the need for more medication.
- The medication costs must be borne by the patient or another payer.

Recommendations:

Given the challenges to the effective prescription of psychotropic medication that have been described above, the following recommendations may help practitioners to avoid unnecessary and/or dangerous polypharmacy:

1. Do not rely on anecdotal reports, "word of mouth" experiences, but instead always consider available evidence. Double–blind placebo controlled clinical studies are the gold standard and should be considered primarily. When empirical evidence is lacking, an alternative source for guidance comes from the consensus of experts.
2. Psychotropic medications should only be prescribed after a thorough biopsychosocial evaluation. In complex cases, evaluation should include medical and neurological exams, as well as psychological and psychiatric assessments. Psychotropic medications should be targeted at specific symptoms that are related to specific DSM-IV diagnoses.
3. Collaborative treatment planning and education with the patient, parents and/or guardians is essential to ensuring effective treatment, promoting adherence to the treatment regimen and effecting reliability in reporting on persistent symptoms, side effects and significant events to guide continuing treatment.
4. "Medication only" treatment is usually not appropriate, especially in the early stages of intervention. Addition of effective non-medication interventions is indicated for maximum efficacy and improvement. Examples of effective non-medication interventions are Parent Management Training for oppositional behavior and Cognitive Behavioral Therapy for depression and/or anxiety
5. When starting pharmacotherapy, try to start only one at a time, if at all possible. Starting one medication at a time makes judging the effectiveness or adverse effects of that medication much more feasible.
6. When starting a new medication, try to assess symptom change by administering a pre and post symptom scale (e.g., Connors' Teachers Rating Scale or Teacher Report Form for ADHD symptoms, Overt Aggression Scale for Aggression, Young Mania Scale for bipolar disorder) or by quantifying the frequency and severity of target symptoms before and after the medication has been added.

7. If you inherit a patient who is already on multiple medications, try to understand the history of how your patient ended up on this regimen. Try to determine whether each medication has had positive, negative or no effects. If there is no evidence that a particular medication has been effective, try to discontinue it slowly and continue to monitor for increased symptoms. If an increase in symptoms is demonstrated, the medication can be re-started.
8. If a child or adolescent has done very well on a medication regimen for 12 months, consider the possibility of discontinuing one of his/her medications.

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